Inpatient Outcomes Initiative

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The Inpatient Outcomes Initiative (IOI) is designed to look at medical necessity and treatment process for a selected group of Medicaid beneficiaries being served in either Psychiatric Residential Treatment Facilities (PRTFs) or Inpatient Psychiatric Hospitals (IPH). The IOI was created in July of 2016 by the Director of Behavioral Health and assigned to the Behavioral Health Quality Assurance (QA) Team. The initiative has two components: Psychiatric Residential Treatment Facilities and Inpatient Psychiatric Hospitals. The two components have similarities in scope but are distinct in methodology.

PRTF IOI

PRTFs are required by SCDHHS policy to have a monthly treatment team staffing for each of their residents. These monthly teams must consist of the psychiatrist, facility treatment staff, beneficiary, family member and any external treatment providers and stakeholders. The PRTF IOI will involve the SCDHHS BH QA team attending the monthly treatment team for 10% of the PRTF residents who receive SC Medicaid. At any given time there are approximately 240 youth who reside in PRTFs whose stays are paid via SC Medicaid; the QA team will follow 24 youth to observe treatment process. The sample will be of the youth with the longest lengths of stay accounting for all fourteen PRTFs. The QA team will review clinical documentation in advance of the meeting and attend in person the actual treatment team. The QA team will be looking at three key elements: recidivism, family involvement and serious occurrences. Follow up phone consultations will be done to address any issues with either the clinical record or the meeting itself.

IPH IOI

The inpatient initiative will consist of a comprehensive post payment review of the clinical and medical documentation of 10 of beneficiaries ages 0-21 who have spent the most time in an acute inpatient setting during FY16. The QA team will be looking at three key elements: medical necessity, treatment course and discharge planning.

Background

Acute Inpatient Psychiatric Hospitalizations

During state fiscal year 2015, the number of Medicaid beneficiaries under age 21 treated at private inpatient facilities increased 600%. During that time, 4,749 children and youth ages 0 through 21 were treated for psychiatric conditions in inpatient settings. Nearly 15% of children and youth had multiple hospitalizations. One hundred and forty of these children and youth experienced three or more hospitalizations during the 12 month period. One youth was hospitalized 14 times.

The costs of repeated psychiatric hospitalizations are significant. For this group of 4,747 children and youth, total Medicaid-funded health care expenditures during state fiscal year 2015 were $137 million. Nearly 5% of children and youth had total Medicaid expenditures over $100,000. The average expenditure was nearly $29,000.

While the lengths of stays at these hospitals are relatively brief, they are expensive; repeated admissions result in more costs to the Medicaid and reflect less stability for the children and youth.

Psychiatric Residential Treatment Facility Stays

Length of Stay: SCDHHS contracts with a Quality Improvement Organization (QIO) to do prior authorizations (PA) and quality reviews for PRTFs. The initial PA is for 21 days; subsequent PAs are for periods of no more than 30 days. Additionally the QIO generates reports for SCDHHS both regularly

and on demand. It has been a challenge to get a true average length of stay (LOS) for SC Medicaid children and youth in PRTFs. Our QIO measures LOS per PRTF which means if a child transfers to another PRTF it begins a new count of days. Additionally, if a child is discharged from a PRTF but fails once in the community and is sent back to either the same or another PRTF, that is treated as a new stay. SCDHHS internal numbers show a LOS of 164 days but that is average; there are children who remain in this level of care for years.

Quality Oversight and Medical Necessity

While there is some utilization oversight by a Quality Improvement Organization, the document sets submitted each month for prior authorization are completed by the facility staff; creating a perverse incentive to keep the beneficiary in their facility.

Drivers

1) In July 2014 a policy change was made that removed state agencies as the sole referring authority to PRTFs. Now instead of having to go through a state agency, families, pediatricians, clergy, essentially any concerned party could refer a youth to a PRTF. This referral process was done with the intention of increasing access to care and freedom of choice for youth and families. Under the old system, if a state agency made a referral to a PRTF they were responsible for the state match. For every Medicaid dollar that is spent in South Carolina, seventy cents comes from the Federal Government and thirty cents must be covered by state resources. This means under the prior system if a state agency referred a youth to a PRTF that cost $300 per day, that state agency was paying $90 per day. While state agencies were always judicious about making these PRTF referrals, the Recession of 2009 exacerbated the process. With slashed budgets, state agencies were put in the difficult position of making treatment

decisions based on financial constraints outweighing clinical concerns. SCDHHS leadership decided that in addition to removing state agencies as the sole referring authority to PRTFs, it would also take over the match for any state agencies who did refer their youth to a PRTF. Almost immediately parents began the process of placing their children in PRTFs. This filled up the PRTF beds quickly resulting in a swell of admissions for beneficiaries ages 0-21 in psychiatric hospitals.

2) PRTFs are reimbursed on a per diem rate. The current rate paid by SC Medicaid averages $305.00 per day (PRTF rates are based on individual cost reporting so there is variance in daily rate from facility to facility). Neighboring states reimburse at higher rates; North Carolina pays $100 more per day. This has resulted in more and more out of state children and youth being served by PRTFs located in South Carolina. Of the existing 691 PRTF beds in South Carolina, approximately 416 of them are filled by South Carolina youth. The remaining 275 are filled by out of state youth. Of the 14 PRTFs in the state only two serves solely South Carolina youth. One facility serves children from 13 states, including Hawaii.

This project involves evaluation of discharge and transition planning from both PRTF and inpatient psychiatric hospitals as well ongoing monitoring of a sample of beneficiaries who are currently in PRTFs. Findings will inform analysis of existing policies and development of future policies with a goal to keep children and youth in their homes and communities. Research has shown that effective home and community-based services are less costly and provide better outcomes for children, youth, and their families. (Blau, 2014) Decreasing the number of inpatient hospitalizations and decreasing length of stays in PRTFs should result in significant cost savings to the agency as well as better treatment outcomes for children, youth and their families.

PRTF IOI Activities

On October 3, 2016 PRTF operators were sent a letter from the Director of Behavioral Health announcing the initiative and what it would entail. After the initial announcement letter, emails were sent from the Behavioral Health Quality Assurance Team Leader to the PRTF operators requesting the date of a specific beneficiary (ies) monthly treatment team meeting. A sample size of 10% (24 beneficiaries) were chosen based on the following criteria:

- Length of Stay (LOS) at the facility—the children and youth who had been at a PRTF the longest
- Representation from all 14 PRTFs

As of 1.31.17, IOI team has participated in 43 monthly treatment team meetings of 27 beneficiaries at 11 PRTFs.

A Typical Meeting

Meetings are required to be held every thirty days. The current manual states that providers must invite family members and that out patient service providers should make every effort to attend. Treatment team meetings are typically attended by the following PRTF facility staff: Psychiatrist, Clinical Director, Therapist, Nurse, Teacher and Activity Therapist. Meetings are normally led by Psychiatrist or Therapist reviewing beneficiary's treatment goals and behavior for the past 30 days. They also discuss any changes to medication, discharge plans and any barriers as well. Feedback is obtained from the beneficiary regarding their view of treatment, progress toward goals, and/or areas of improvement. Parents/Guardians are at times on the telephone and will also share feedback and/or concerns. Therapist often provides updates from case managers if the beneficiary has an open case with other state agencies: DDSN, DSS or SC Continuum of Care. Treatment team members or those in attendance are given opportunity to make suggestions or ask additional questions prior to end of the meeting. Often times, SCDHHS staff will ask additional questions as a result of reviewing clinical documents provided.

Rarely are family members or outpatient providers present at these meetings. In speaking with both PRTF providers and outpatient (community) providers there is a disconnect as to why they are not coming together. The community providers say that they are not invited and at times actively discouraged from attending. The PRTF providers have alleged that community providers will not return their calls nor attend meetings. The Director of Behavioral Health has offered to intercede on behalf of both groups to facilitate collaboration. To date neither provider group has asked for assistance.

Initial findings were significant in the following areas:

Immediate Discharge

Seventeen of the first group of youth (N=22) were slated to be discharged the following week of when SCDHHS sent the youth's name to the facility. These youth were chosen specifically for their significant length of stays yet were discharging almost immediately after SCDHHS requested to attend the treatment team.

While this finding was not surprising, the volume was shocking. Over 75% of the longest staying youth were coincidentally ready for discharge once their name was submitted for SCDHHS involvement. A cornerstone of health care is the concept of *medical necessity.* Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. (American College of Medical Quality, 2010)

CMS's glossary defines medical necessity as, "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of you or your doctor". (CMS, 2016) Medical Necessity is what drives treatment planning decisions throughout all levels of physical and behavioral health care. Public and

private health insurers require comprehensive use of sound medical necessity criteria as part of the reimbursement process.

Ready for Discharge, Nowhere to go

Six of the initial twenty-two beneficiaries were determined to no longer need placement at the PRTF but were staying there due to not having anywhere to go. In a couple of instances the parents did not want the youth back. Once SCDHHS stepped in, the PRTF involved DSS in one of these cases which forced the issue and the parent eventually picked up the child. In another instance the child did not want to return to the family home and said they would run away if returned there. In a third case the PRTF was awaiting a home study by DSS to ensure the youth's aunt could take the child. In another instance, the PRTF was waiting on a Community Training Home bed for over five months while the youth as ready for discharge. A final instance had conflicting information told to SCDHHS and SCDJJ regarding the status of a youth's readiness for discharge. This area of finding was shocking. Over 25% of the initial sample was being held at the PRTF for no other reason than nowhere else to go. This is a major concern given the fact that we know that long term stays in PRTFs can be detrimental to youth. (Poertner, 2001, pp. 495-513) Finally, leaving a youth in a more restrictive environment is both clinically problematic as well as financially risky. Without medical necessity the facility is at risk for recoupment by both public and private payers. Additionally, a finding from the Centers for Medicare and Medicaid Services (CMS) that SCDHHS is paying for placements without medical necessity puts the state of South Carolina at risk for recoupment of the federal match of these payments. This finding resulted in SCDHHS getting in immediate touch with our Quality Improvement Organization, QIO, who does the prior authorizations for initial and continued stays at the PRTFs. The document set for continued stays is the current Plan of Care as well as the most current Progress Summary. The QIO agreed that there were both understanding issues and content issues with regard to the document set submitted monthly. Some

PRTFs kept the initial admission summary on the front page of their Plans of Care, giving the impression that the presenting symptoms and behaviors of the initial admission (often from a year earlier) were still current. SCDHHS requested that QIO clinical reviewers read the actual updated POC notes from that particular month. Additionally, it was found that more telling details about readiness for discharge were found in the monthly treatment team notes. Draft language to change the document set to include the monthly treatment team notes has been completed and is will be included with sweeping policy changes planned for July 1, 2017.

Additionally, agency leadership, including Office of General Counsel, were apprised of the findings as well as follow up with QIO to ensure medical necessity is met for continuing reviews.

Discharge Expedited

In six cases, youth who had been in the facilities over a year were being set for discharge two months after SCDHHS became involved. This finding evokes the same concern as those who were immediately discharged upon the facilities' notification that SCDHHS would be participating in their monthly treatment planning meetings. It gives the appearance that strenuous discharge planning was not taking place until active oversight commenced.

Family/Beneficiary Absent from Treatment Team

In 43 monthly treatment meetings, family members were absent from 36 of them; while youth missed on eight occasions. The lack of family involvement is greatly concerning. When 84% of the meetings lack family presence we are in need of a major overhaul to address this. SCDHHS has committed to the philosophy of the Building Bridges Initiative (Blau, 2014), which is about strengthening the collaboration between community providers and residential providers. Three core values of BBI is that treatment is Youth Guided, Family Driven and Culturally and Linguistically Competent. Regular

convening of Child and Family Teams (CFT) show shorter stays and greater strides in treatment. (Blau, 2014)

Despite our current policy manual requiring family members to be present at the monthly treatment team, they were absent over 80% of the time. When SCDHHS team members inquired, it was not uncommon to hear that the parents worked and could not make the meeting. Rather than make things uncomfortable for the beneficiary who is usually at the table, we now follow up with the clinical director regarding flexing meeting times to accommodate parents' work schedules.

Responsiveness of Provider/Adherence to Policy

To date, two facilities have not yet been visited, although the initiative kicked off in late October. Initially they did not respond to outreach attempts; when we were able to finally track them done via phone comments were made such as "we don't have a monthly treatment team meeting" and "we don't have a meeting monthly where all treatment personnel are in the same room". Both of these are in violation of SCDHHS policy and we are in process of reaching out again to these providers to gain clarity on the status of their treatment team meetings.

Discharge Planning

One provider stated they had planned on discharging all Medicaid beneficiaries in advance of a previously planned January 1, 2017 carve in of PRTF services to the managed care benefit. This date has been moved back to July 1, 2017. It is very unlikely that a swath of youth who happen to share the same insurance payer are ready for discharge at the same time that happens to coincide with an anticipated change in oversight (as provided by the MCOs)

Lessons Learned and Next Steps

1. The question of medical necessity has been and will continued to be addressed both with our QIO as well as internally with our Office of General Counsel and Division of Program Integrity. Since the QIO did in fact authorize continued stays for those beneficiaries who in retrospect had questionable medical necessity it is not feasible to pursue recoupment at this time but to focus on ensuring that the QIO is reviewing relevant and current information to inform the PA process.
2. The lack of family involvement will be addressed with policy changes set to go into effect July 1, 2017. The PRTF section of the Inpatient Psychiatric Hospitals manual has been infused with language taken from the principles of the Building Bridges Initiative (BBI). We contracted with a BBI consultant who reviewed our manual and provided comprehensive feedback on language changes that steer providers towards more family and youth inclusion.
3. A Summary of Policy Changes to take place beginning July 1, 2017:

PRTF Policy Updates

- **Language reflecting Building Bridges Initiative has been added throughout the manual**
  - Treatment in least restrictive setting
  - Importance of child and family team
    - Integrated into all aspects of its programming (staffings, visits etc.).
    - Treatment plans for children in PRTFs will always exist only as a part of the dynamic team's overall plan for the child and family.
    - PRTF providers must work with community providers, referral sources and families to initiate formation of a planning team when children are admitted without one.
    - Goals and objectives for the beneficiary that are primarily designed to prepare the child and family for the child's return home; are measurable and time-limited
    - Children must be treated within the context of their family systems.
    - Family and ethnic/racial culture should be assessed and considered in the formulation of a treatment approach,
    - PRTF providers must encourage and support family members/ caregivers to be actively and meaningfully involved in all aspects of the child's care.
    - Each family should be encouraged to use the child's placement as a transition period, helping the family as a whole to start on a new path

- Programming (e.g. level systems) within group settings must address each child's specific needs, reflect each child's preference and unique capabilities, and must be adaptable and transferable to each family's situation.
- PRTF program settings must provide as natural and home-like an environment as possible.
- Phone calls, family visits and other experiences should not have to be earned
- Participation in family-focused therapy should be a primary objective in many PRTF placements.
- Discharge plans should build on identified strengths and cultural priorities, and should incorporate families' natural supports as well as professional services.
- If families are unable or unwilling to participate in their care, providers must work through the child and family team to continually pursue an effective level of engagement with the family, at times even extending to other relatives beyond the immediate family.
- Some children referred to a PRTF do not reside with biological families. SCDHHS expectations and requirements for family involvement, family voice and choice extend to the wide diversity of primary caregivers
- Including biological, adoptive, foster, or fictive kin residing together in which adults perform the duties of parenthood for the children. ("Home" refers to the residences of those families.)
- Older youth who may not have an identified family to return to, must be assisted in developing ties to their community, to non-family resources upon which they can depend for assistance, and with caregivers who can help to meet their relationship needs.

➢ Treatment for child success in the home and community vs. facility

- **Core principles and best practice approaches affirmed by the weight of empirical evidence and consensus of clinical mental health professionals**
  - ➢ U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA)
  - ➢ Jointly by SAMHSA and the Centers for Medicare and Medicaid Services (CMS), based on evaluation of five-year demonstration of the CHANCE waiver
  - ➢ Underpinning the American Association of Community Psychiatrists' Child and Adolescent Level of Care Utilization System (CALOCUS)
  - ➢ The Palmetto Coordinated System of Care.
- **PRTF programs should be regarded as community resources within the Palmetto Coordinated System of Care, and not as "placements."**
- **Seclusion and restraint expectations**
  - ➢ Must develop behavior support and teaching techniques that are strength-based, that promote self-regulation and self-monitoring
  - ➢ Should strive to eliminate coercion and coercive interventions (e.g. seclusion, restraint, response-cost and other aversive practices), and provide care that is trauma-informed and uses relevant data and feedback in rigorous processes of continuous improvement.
- **Additional training requirements (e.g. Mental Health First Aid)**

- **Child and Adolescent Level of Care Utilization System performed every six months**
- **Transition of Care/Continuity of Care Expectations**
  - In preparing for and accomplishing transition and discharge, continuity of care must be maintained. Both PRTF and community providers should adjust staffing models and patterns, contracting mechanisms and job descriptions to encourage individualized interventions and enduring therapeutic relationships that are not disrupted by changes in residence.
  - Out of home service providers are encouraged to make the skills and expertise of their workforces available to help support the family, school and community to provide special attention to successfully transition the child home, and even to help address the needs of the child and family after discharge.
  - Providers should actively strive to expand the variations of service they provide, and integrate them with community based programs to effectively stabilize and strengthen family home and community living options for children.
  - Requires coordination and continuity of care for beneficiaries, including between care settings.

- **Therapeutic Home Time: Beneficiaries may receive up to 14 days per state fiscal year of Therapeutic Home Time (THT). THT involves allowing the youth to begin the transition process as they stay at home with their family. These 14 days are considered reimbursable as part of the youth's residential intervention.**

4. PRTF services will be added to the Managed Care Benefit effective July 1, 2017. On July 1, 2016, outpatient behavioral health services were added to the Managed Care Benefit. Prior to that all the behavioral health services had been in what is known as "Fee for Service" or traditional Medicaid. The 2016 carve was done with an aim to ensure integration of primary and behavioral care. The carve-in of the PRTF benefit is a natural extension of this effort and will ensure coordination of care on the continuum of outpatient to inpatient care. Further, it will provide much needed oversight as to adherence to policy and particularly pay attention to medical necessity in a manner that ensures that stays are reflective of clinical need.
5. PRTFs can have treatment team on the same day involving staff having to crisscross the state to make each meeting. This has put a significant drain on available staff. The implementation of Fair Labor Standards Act (FLSA) in November 2016 also compromised staff ability to work long

hours in a day or week. Some PRTFs have their meetings 3:30-5:30; when the facility is two hours away from Columbia we have staff having to proactively flex their hours in order to maintain compliance with FLSA. As we work with PRTFs to schedule their monthly treatment teams in a way that honors the family member's availability we anticipate more scheduling challenges for agency staff. There may be evening or weekend treatment meetings that we must schedule proactively to ensure compliance with FSLA as well as staff's off work time.

6. The Division of Behavioral Health has done some informal reporting at stakeholder meetings including the Palmetto Coordinated System of Care (PCSC) planning group. Initial feedback has been positive with SCDSS noting a seeming opening up of the waiting lists for DSS beneficiaries. In the past wait lists have resulted in these youth being sent to out of state PRTFs, this seems to be mitigated in the last several weeks, perhaps due to the IOI efforts.

IPH IOI Activities

When the IOI initiative was created the Behavioral Health Quality Assurance team had two vacant staff positions on a five person team. The decision was made to start with the PRTF IOI since there has been tremendous pressure to open up PRTF beds in state. Once the QA team is fully staffed the IPH IOI will begin. It is projected that will be in spring of 2017.

Evaluation

The Inpatient Outcomes Initiative was born out of data showing spikes in acute inpatient psychiatric stays for beneficiaries 21 years of age and younger. It is believed that a change in referral process resulted in the unintended consequence of youth being placed in PRTFs and staying for many months and in some cases several years. Because the lower level of care (PRTF) was bottlenecked, youth were having to go to Emergency Departments and eventually admitted to acute inpatient psychiatric hospitals.

The IOI's goal is to reduce frequency and length of stay of both acute inpatient psychiatric hospitalizations and PRTFs. Since the policy changes and carve in to the managed care benefit takes place on July 1, 2017, we will be able to do a meaningful evaluation on the impact when we procure cost and stay data for FY18 (available in September of CY18). In the meantime, the PRTF portion of the IOI will continue to be evaluated in real time. We have already received anecdotal feedback from the Department of Social Services on the availability of in-state beds for placements. This is very significant as we have had nothing but complaints of no bed availability since the policy change in July 2014. Additional "real time" data we expect to track as early as August of CY17 is family involvement in monthly treatment team meetings and use of therapeutic home time. We have already seen and expect to continue to see expedited discharges due to increased oversight by SCDHHS at the monthly treatment meetings. In summary, evaluation efforts will be both quantitative (claims and stay data) and qualitative (family participation in treatment, discharge planning from admission, use of therapeutic home time).

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